COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
VERIFICATION OF DRUG MEDI-CAL (DMC) ELIGIBILITY REQUEST FORM

SUBMIT VERIFICATION FORM TO:
Website: http://publichealth.lacounty.gov/sapc/
Fax: (626) 299-XXXX

1. (Check One): ☐Verification ☐Reverification ☐Expedited Verification*		2. Verification Number:
3. Dates Service Requested: From: _____ To: _____		
PATIENT INFORMATION		
4. Name (Last, First, and Middle):	5. Date of Birth (MM/DD/YY):	6. Medi-Cal Number:
7. Address:		
8. Phone Number: Okay To Leave a Message? ☐ Yes ☐ No		9. Gender:
10. Perinatal Patient: ☐ Yes ☐ No	11. Criminal Justice Involved Patient ☐ Yes ☐ No	12. Race/Ethnicity (Optional):
PROVIDER AGENCY INFORMATION		
13. Provider Agency Name:	14. Phone Number:	15. Fax Number:
16. Address:		17. Email Address:
18. Name and Work Title of the Contact Person:		19. Phone Number of the Contact Person:
ELIGIBILITY FOR MEDI-CAL		
20. Does the Patient Reside Within Los Angeles County? ☐ Yes ☐ No		
21. Is the Patient's Medi-Cal Eligibility Verified? ☐ Yes ☐ No		
MEDICAL NECESSITY DETERMINATION		
22. Current DSM-5 Diagnosis(es), or (if applicable) justification of why youth under age 21 is assessed to be at-risk for developing substance use disorder: _____ _____ Date: _____		
23. Current ASAM Level of Care: _____ Date: _____		
24. Name and Credential of the LPHA Who Determined Medical Necessity: _____		
25. Date Medical Necessity Was Determined: _____		
REQUIRED DOCUMENTATION		
FOR VERIFICATION OR EXPEDITED VERIFICATION: Submit verification forms prior to initiation of services. Required documents: Verification of DMC Eligibility Request Form and assessment information. **FOR REVERIFICATION**: Reverification request must be submitted at least 21 calendar days in advance of the end date of current verification. Required documents: Verification of DMC Eligibility Request Form, current treatment plan, assessment information, progress notes, and relevant laboratory/drug test results (if available).		
INTERNAL SAPC USE ONLY		
☐ Approved ☐ Denied. If Denied, Reason(s):_____ Reviewed by:_____ Date:_____		

Client Name: _____ **Medi-Cal ID:**_____

Treatment Agency: _____

VERIFICATION OF DRUG MEDI-CAL (DMC) ELIGIBILITY REQUEST FORM INSTRUCTIONS

1. Check the appropriate box for what is being requested: Verification, reverification or expedited verification.

   *Expedited Verification: For cases in which a provider indicates, or the SAPC determines, that following the standard timeframe could seriously jeopardize the patient's life or health or ability to attain, maintain, or regain maximum function, the SAPC will make an expedited verification decision and provide notice as expeditiously as the patient's health condition requires, and no later than 3 working days after receipt of the request for service.
2. If requesting reverification, enter the verification number.
3. Enter the dates for service requested: Enter the date the requested service will begin and the date the requested service will end.

PATIENT INFORMATION

4. Enter the patient's name in the order of last name, first name, and middle name.
5. Enter the patient's date of birth.
6. Enter the patient's Medi-Cal number. Was eligibility verified? Please check yes or no.
7. Enter the patient's address.
8. Enter the patient's phone number. Check yes or no if okay to leave a message at this phone number.
9. Enter the patient's gender
10. Is this a perinatal patient? Please check yes or no.
11. Is this a criminal justice patient? Please check yes or no.
12. Enter the patient's race/ethnicity (optional).

PROVIDER AGENCY INFORMATION

13. Enter the name of the provider agency that is requesting the verification or reverification.
14. Enter the phone number of the provider agency.
15. Enter the fax number of the provider agency.
16. Enter the email address of the provider agency.
17. Enter the address of the provider agency.
18. Enter the name and the work title of the person who can be contacted regarding the request.
19. Enter the phone number of the provider agency's contact person.

ELIGIBILITY FOR MEDI-CAL (May be determined by SUD Counselors and trained support staff)

20. Does the patient reside in Los Angeles County? Please check yes or no.
21. Is the patient's Medi-Cal eligibility verified? Please check yes or no.

MEDICAL NECESSITY DETERMINATION (Determined only by a medical director, licensed physician or LPHA)

22. Enter the current DSM-5 diagnosis, or (if applicable) justification of why youth under age 21 is assessed to be at-risk for developing substance use disorder. Enter the date.
23. Enter the current ASAM level of care.
24. Enter the name and credential of the LPHA who determined medical necessity.
25. Enter the date the medical necessity was determined.

REQUIRED DOCUMENTATION

FOR VERIFICATION OR EXPEDITED VERIFICATION: Submit verification forms prior to initiation of services. Required documents: Verification of DMC Eligibility Request Form, and assessment information.
FOR REVERIFICATION: Reverification request must be submitted at least 21 calendar days in advance of the end date of current verification. Required documents: Verification of DMC Eligibility Request Form, current treatment plan, assessment information, progress notes, and relevant laboratory test results (if available).

*LPHA (Licensed Practitioner of the Healing Arts) includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

INTERNAL SAPC USE ONLY

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